Health History

Patient name: _____ Date: _____

Date of Birth: _____ Email: _____

Address: _____ City/State/Zip: _____

Driver's License #_____ State issued: _____

Sex: □ M □ F □ Married □ Single □ Divorced □ Widowed □ Separated

Occupation: _____ Employer: _____

Spouses Name: _____ Spouses occupation: _____

Children: _____

Who may we thank for referring you? _____

Phone number: Cell _____ Home _____

Emergency Contact: _____ Phone # _____

Relationship to patient: _____

Reason for visit: _____

Is this due to an accident? □ Yes □ No If yes, what kind?: □ Auto □ Work related □ Home

Has it been reported to: □ Insurance company □ Employer □ Work Comp

When did the symptoms appear? _____ Is the condition getting worse? □ Yes □ No

How often do you have this pain? _____ Pain: □ is constant □ comes and goes

Does it interfere with: □ Work □ Sleep □ Recreation □ Daily routine □ _____

Are the following painful or difficult? □ Sitting □ Standing □ Walking □ Lying □ Bending □ Lifting

□ Other _____

Rate your pain from 1-10 _____

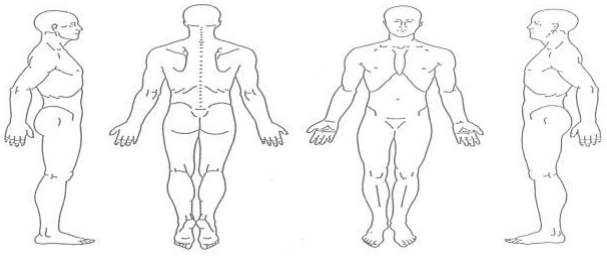
Do you feel the following?:

□ Numbness □ Tingling □ Weakness

□ Sharp □ Dull □ Ache □ Throbbing

□ Burning □ Swelling □ Stiffness □ Cramps

Using the drawing below, where do you feel the pain?



How does your condition make you feel? _____

What would you be able to do/enjoy that you can't currently if this condition was gone?

_____

Have you been treated for this condition previously? □ Yes □ No If yes, please check all that apply:

□ Medication □ Surgery □ Chiropractic □ Nutrition □ Acupuncture □ Other _____

Date of last exam: Physical _____ Blood work _____ Urine _____

X-Rays_____ MRI/CT/Ultrasound _____

Have you had or currently have any on the following:

AIDS	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No	Allergy shots	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Anorexia	☐ Yes ☐ No	Appendicitis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Autoimmune	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	↑ Blood pressure	☐ Yes ☐ No	Breast lump	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Bulimia	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Chemical	☐ Yes ☐ No	Chicken pox	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Dependency		Emphysema	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Goiter	☐ Yes ☐ No
Gout	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Hernia	☐ Yes ☐ No	Herniated Disc	☐ Yes ☐ No	Herpes	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Measles	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Mumps	☐ Yes ☐ No
Mononucleosis	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No	Pinched nerve	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Prostate problem	☐ Yes ☐ No	Polio	☐ Yes ☐ No
Prosthesis	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Rheumatoid	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Arthritis		Suicide attempt	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Thyroid Problem	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Typhoid fever	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	Vaginal	☐ Yes ☐ No
Venereal disease	☐ Yes ☐ No	Whooping cough	☐ Yes ☐ No	Infections	

Other: _____

Do you get headaches? ☐ Yes ☐ No How often?_____

How would you describe them? ☐ Migraine ☐ Visual disturbance ☐ Nausea ☐ Tension ☐ Vomiting
☐ Aura ☐ Light sensitive ☐ Related to allergies ☐ Ocular migraine

Are you pregnant? ☐ Yes ☐ No Due Date_____

Have you ever taken antibiotics? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Have you used hormone replacement? ☐ Yes ☐ No

Are you Vegetarian? ☐ Yes ☐ No Do you skip meals? ☐ Yes ☐ No

Amount of sugar you eat? ☐ Low ☐ Moderate ☐ High Do you crave sugar? ☐ Yes ☐ No

Do you smoke? _____ How many years?_____ How many times a day?_____, a week? _____

Have you ever smoked?_____ How many years? _____ When did you quit?_____

Falls_____ Date _____

Head injuries_____ Date _____

Broken Bones_____ Date _____

Auto Accidents_____ Date _____

Surgeries_____ Date _____

Any birth/delivery complications?_____

Any developmental delays for age? (ie., crawling, walking, talking, reading, etc.)

_____

Any behavioral issues? _____

Any sleep issues? Yes / No – If yes, describe:_____

Any known reactions when/after given vaccinations? _____

_____

Do parents have any known food allergies? □ Yes □ No – If yes, to what:_____

Infant: Spitting Up □ Yes □ No – If so, how frequently?

_____

Infant: On formula? □ Yes □ No – If so, what type?_____